Tobacco Free Nova Scotia

CONFIDENTIAL

Fax Referral Form

902-407-9898

Tobacco Free Nova Scotia

http://tobaccofree.novascotia.ca

8-1-1

Nova Scotia

Healthcare Provider Referral Source – Required – Please Print

Healthcare provider (select one)

Physician Nurse Dentist Pharmacist Respiratory Therapist Other (specify)_____

Contact information of Referring Healthcare Provider
(or include fax transmissible stamp with equivalent information)

_____ _____
First Name Last Name

(___)_____ (___)_____
Telephone Fax

Patient/Client – Contact Information – Required – Please Print

_____ _____
FIRST NAME LAST NAME

_____ _____
STREET ADDRESS CITY/TOWN

_____ _____ _____
PROVINCE POSTAL CODE BIRTHDATE (mm/yyyy)

(_____) _____
TELEPHONE
Home Cell Work

_____
EMAIL ADDRESS (optional)

Language preference of service
English French
Interpreter requested (specify language)_____

Gender
Male Female Other

Tobacco Free Nova Scotia usually calls the client within 3 business days of receiving referral. When should we call?

Please call me in the Morning Afternoon Evening Anytime

May we leave a message identifying ourselves as Tobacco Free Nova Scotia? Yes No

Patient/Client-Information Consent

I give permission for this form to be faxed to Tobacco Free Nova Scotia, so that Tobacco Free Nova Scotia can contact me regarding my attempt to quit smoking, and also for Tobacco Free Nova Scotia to communicate with my healthcare provider. I understand Tobacco Free Nova Scotia will keep my information confidential and will only use it for the purpose of administering the fax referral program

_____ _____
SIGNATURE OF CLIENT DATE (mm/dd/yyyy)